STATE OF DELAWARE DEPARTMENT OF TRANSPORTATION
DIVISION OF MOTOR VEHICLES
DRIVER IMPROVEMENT UNIT - MEDICAL RECORDS SECTION
PO BOX 698 - DOVER, DE 19903-0698

MEDICAL REPORT OF PHYSICIAN'S FINDINGS

Name: _____ DOB ___/___/___ License Number: _____

Address: _____

I hereby authorize Doctor _____ to perform any medical examination necessary for the purpose of determining my fitness to operate a motor vehicle. Also I understand that this authorization includes permission for the Director of Motor Vehicles and/or their designee to have this information reviewed by a Medical Board of unidentified physicians for the purpose of giving him/her a medical opinion on my case for a guidance in determining my medical capabilities to operate a motor vehicle safely. The information contained in this report is confidential and will be used solely for the purpose of drivers license considerations.

_____ _____
Date Signature of Applicant *(Required)*

(Legibility is a must)

Mental level for reading (circle one) Inadequate - Marginal - Adequate Height: _____ Weight _____

(A) **ORTHOPEDIC AND NEUROMUSCULAR**: *(Please check as appropriate)*

Spastic, Amputations or Ankylosed Joints ☐ YES ☐ NO Joint Ataxia, Paralysis, or Weakness ☐ YES ☐ NO
Prosthetic Devices used for Driving ☐ YES ☐ NO Other Deformities or Abnormalities ☐ YES ☐ NO
If **YES** to any of the above, please describe: _____
_____
_____

(B) **CARDIO-VASCULAR**: *(Please check as appropriate)*

Strokes - Adams Syndrome ☐ YES ☐ NO Syncope ☐ YES ☐ NO Vertigos ☐ YES ☐ NO
Angina Pectoris ☐ YES ☐ NO Arteriosclerosis ☐ YES ☐ NO Arrhythmia ☐ YES ☐ NO
Cardiac Decompensation ☐ YES ☐ NO Dyspnea ☐ YES ☐ NO Blood Pressure _____
If **YES** to any of the above, please describe: _____
_____
_____

(C) **DIABETES**: *(Please check as appropriate)*

Is he/she a known diabetic? ☐ YES ☐ NO Status of Control _____
Duration: _____ Diabetic Acidosis ☐ YES ☐ NO _____
If **YES** to any of the above, please describe: _____
_____
_____

(D) **HEARING**: Normal? ☐ YES ☐ NO If **NO**, please describe: _____
_____

(E) **DRUGS AND/OR ALCOHOL**: *(Please check as appropriate)*

Any objective evidence or personal knowledge of addiction, habituation, or alcoholism? ☐ YES ☐ NO
If **YES**, please explain: _____

 Patient Name: _____ DOB ___/___/___

(F) **PSYCHOLOGICAL ASSESSMENT**: *(Please check as appropriate)*

Is there any evidence of emotional instability? ☐ YES ☐ NO Is further examination suggested? ☐ YES ☐ NO
Does he/she have or has he/she had any episodes of conditions listed below?
Mental Clouding ☐ YES ☐ NO Blackouts ☐ YES ☐ NO Dizziness ☐ YES ☐ NO
Unconsciousness ☐ YES ☐ NO Convulsions ☐ YES ☐ NO
If **YES** to any of the above, please explain nature and date of last episode:_____
_____
Diagnosis: _____
_____

(G) Does he/she have any other condition or diseases which would decrease ability to safely operate a motor vehicle? *(Please check as appropriate)* ☐ YES ☐ NO
If **YES**, please explain: _____
_____

(H) What type(s) and quantities of drugs are being prescribed for the patient? _____
_____
_____

(I) Do any of the above medications affect driving ability? *(Please check as appropriate)* ☐ YES ☐ NO
If **YES**, please explain: _____
_____

(J) From a medical standpoint, do you feel he/she is capable of operating a vehicle safely? ☐ YES ☐ NO
If **NO**, please explain: _____
_____
_____

If <u>YES</u>, the treating physician must attest to one of the two below listed statements, as may be applicable, for any person who is subject to loss of consciousness due to disease of the central nervous system.

☐ I hereby certify that I am the treating physician duly, licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's infirmity is under sufficient control to permit him/her to operate a motor vehicle with safety to person and property.

☐ I hereby certify that I am the treating physician, duly licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's disease no longer requires treatment and that such person can reasonably expect to suffer no further losses of consciousness on account of such disease.

(K) How long have you been treating this patient? _____ Date of last examination: ___/___/___

(L) Additional comments: _____
_____
_____

_____ _____
Physician's Name (Printed or typed) Physician's Signature

_____ _____
Address Phone Number
_____ Date: _____

Please mail form to: MEDICAL RECORDS SECTION - DRIVER IMPROVEMENT UNIT - PO Box 698 - Dover, DE 19903-0698
The form may be transmitted by facsimile to: (302) 739-5667 ATTN.: MEDICAL RECORDS SECTION